

Centers for Medicare & Medicaid Services, HHS

§ 447.54

(c) In states that do not have fee-for-service payment rates, cost sharing for prescription drugs imposed on individuals at any income level may not exceed the maximum amount established for individuals with income at or below 150 percent of the FPL in paragraph (b) of this section.

(d) For individuals otherwise exempt from cost sharing under § 447.56(a), the agency may impose cost sharing for non-preferred drugs, not to exceed the maximum amount established in paragraph (b) of this section.

(e) In the case of a drug that is identified by the agency as a non-preferred drug within a therapeutically equivalent or therapeutically similar class of drugs, the agency must have a timely process in place so that cost sharing is limited to the amount imposed for a preferred drug if the individual's prescribing provider determines that a preferred drug for treatment of the same condition either will be less effective for the individual, will have adverse effects for the individual, or both. In such cases the agency must ensure that reimbursement to the pharmacy is

based on the appropriate cost sharing amount.

§ 447.54 Cost sharing for services furnished in a hospital emergency department.

(a) The agency may impose cost sharing for non-emergency services provided in a hospital emergency department. The provisions in § 447.56(a) shall apply except as the agency exercises the option under paragraph (c) of this section.

(b) At state option, cost sharing for non-emergency services provided in an emergency department may be established at or below the amounts shown in the following table (except that the maximum allowable cost sharing identified for individuals with family income at or below 150 percent of the FPL shall be increased each year, beginning October 1, 2015, by the percentage increase in the medical care component of the CPI-U for the period of September to September of the preceding calendar year, rounded to the next higher 5-cent increment):

Services	Maximum allowable cost sharing	
	Individuals with family income ≤150% of the FPL	Individuals with family income >150% of the FPL
Non-emergency Use of the Emergency Department	\$8	No Limit.

(c) For individuals otherwise exempt from cost sharing under § 447.56(a), the agency may impose cost sharing for non-emergency use of the emergency department, not to exceed the maximum amount established in paragraph (b) of this section for individuals with income at or below 150 percent of the FPL.

(d) For the agency to impose cost sharing under paragraph (a) or (c) of this section for non-emergency use of the emergency department, the hospital providing the care must—

(1) Conduct an appropriate medical screening under § 489.24 subpart G to determine that the individual does not need emergency services.

(2) Before providing non-emergency services and imposing cost sharing for such services:

(i) Inform the individual of the amount of his or her cost sharing obligation for non-emergency services provided in the emergency department;

(ii) Provide the individual with the name and location of an available and accessible alternative non-emergency services provider;

(iii) Determine that the alternative provider can provide services to the individual in a timely manner with the imposition of a lesser cost sharing amount or no cost sharing if the individual is otherwise exempt from cost sharing; and

(iv) Provide a referral to coordinate scheduling for treatment by the alternative provider.

(e) Nothing in this section shall be construed to:

(1) Limit a hospital's obligations for screening and stabilizing treatment of

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an emergency medical condition under section 1867 of the Act; or

(2) Modify any obligations under either state or federal standards relating to the application of a prudent-layperson standard for payment or coverage of emergency medical services by any managed care organization.

§ 447.55 Premiums.

(a) The agency may impose premiums upon individuals whose income exceeds 150 percent of the FPL, subject to the exemptions set forth in § 447.56(a) and the aggregate limitations set forth in § 447.56(f) of this part, except that:

(1) Pregnant women described in described in paragraph (a)(1)(ii) of this section may be charged premiums that do not exceed 10 percent of the amount by which their family income exceeds 150 percent of the FPL after deducting expenses for care of a dependent child.

(i) The agency may use state or local funds available under other programs for payment of a premium for such pregnant women. Such funds shall not be counted as income to the individual for whom such payment is made.

(ii) Pregnant women described in this clause include pregnant women eligible for Medicaid under § 435.116 of this chapter whose income exceeds the higher of –

(A) 150 percent FPL; and

(B) If applicable, the percent FPL described in section 1902(l)(2)(A)(iv) of the Act up to 185 percent FPL.

(2) Individuals provided medical assistance only under sections 1902(a)(10)(A)(ii)(XV) or 1902(a)(10)(A)(ii)(XVI) of the Act and the Ticket to Work and Work Incentives Improvement Act of 1999 (TWWIIA), may be charged premiums on a sliding scale based on income.

(3) Disabled children provided medical assistance under section 1902(a)(10)(A)(ii)(XIX) of the Act in accordance with the Family Opportunity Act, may be charged premiums on a sliding scale based on income. The aggregate amount of the child's premium imposed under this paragraph and any premium that the parent is required to pay for family coverage under section 1902(cc)(2)(A)(i) of the Act, and other cost sharing charges may not exceed:

(i) 5 percent of the family's income if the family's income is no more than 200 percent of the FPL.

(ii) 7.5 percent of the family's income if the family's income exceeds 200 percent of the FPL but does not exceed 300 percent of the FPL.

(4) Qualified disabled and working individuals described in section 1905(s) of the Act, whose income exceeds 150 percent of the FPL, may be charged premiums on a sliding scale based on income, expressed as a percentage of Medicare cost sharing described at section 1905(p)(3)(A)(i) of the Act.

(5) Medically needy individuals, as defined in §§ 435.4 and 436.3 of this chapter, may be charged on a sliding scale. The agency must impose an appropriately higher charge for each higher level of family income, not to exceed \$20 per month for the highest level of family income.

(b) *Consequences for non-payment.* (1) For premiums imposed under paragraphs (a)(1), (a)(2), (a)(3) and (a)(4) of this section, the agency may not require a group or groups of individuals to prepay.

(2) Except for premiums imposed under paragraph (a)(5) of this section, the agency may terminate an individual from medical assistance on the basis of failure to pay for 60 days or more.

(3) For premiums imposed under paragraph (a)(2) of this section—

(i) For individuals with annual income exceeding 250 percent of the FPL, the agency may require payment of 100 percent of the premiums imposed under this paragraph for a year, such that payment is only required up to 7.5 percent of annual income for individuals whose annual income does not exceed 450 percent of the FPL.

(ii) For individuals whose annual adjusted gross income (as defined in section 62 of the Internal Revenue Code of 1986) exceeds \$75,000, increased by inflation each calendar year after 2000, the agency must require payment of 100 percent of the premiums for a year, except that the agency may choose to subsidize the premiums using state funds which may not be federally matched by Medicaid.

(4) For any premiums imposed under this section, the agency may waive